In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. The billing office is expected to submit claims for services rendered using valid codes from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code auditing protocols for services/procedures billed.

Implant Payment and Coding Policy

Policy Number: CPCP007

Version: 4.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: 11/07/2018

Effective Date: 12/17/18

Description

The Food and Drug Administration (FDA) defines an implant as a device or tissue that is placed into a surgically or naturally formed cavity of the human body and is intended to remain there for a period of 30 days or more. There may be instances where a device that remains in the body for short periods, less than 30 days, may also be considered as an implant according to the FDA. Implants must also remain in the patient's body upon discharge from the inpatient stay or outpatient procedure. Implants include but are not limited to: anchors, artificial joints, mesh, pins, plates, radioactive seeds, screws, shunts, stents, allografts, and autografts. Other implants deliver medication, monitor body functions, or provide support to organs and tissues.

A supply or instrument that is purposed to be removed or discarded during the same inpatient or outpatient procedure in which they are placed in the body is not an implant. Liquids or materials that are absorbed or incorporated by the surrounding tissue will not be reimbursed if billed as an implant. Additionally, provider or vendor administrative storage and delivery costs will not be reimbursed. Items or services should be all encompassed under the surgical rate charge and therefore the patient should not be responsible for these charges or services. Providers and facilities are urged to utilize implants and supplies in an efficient manner to prevent waste. Some examples of supplies, instruments and miscellaneous items that will not be reimbursed include but are not limited to:

ADVANCED HEMOSTATS & SEALANTS	SYNTHETIC SEALANTS	TOPICAL ABSORBABLE HEMOSTATS (TAH) & TOPICAL THROMBINS	Instruments & Miscellaneous
Surgiflo	Duraseal	Surgicel	Bone Morphogenetic Proteins (BMP)
Evicel	Bioglue	Instant Surgifoam	Guide wires
Floseal	Progel	Arista	Endoscopes
Tisseel	Coseal	Avitene	Catheters
Seprafilm	Omnex	Gelfoam Plus	Staples
		Evithrom	Clips
		Thrombin-JMI	Tubes
		Recothrom	Temporary Drains

Reimbursement Information:

Revenue Code 278 *Other Implants*

- If separately reimbursable, billed charges for revenue code 278 may require a vendor's invoice to support implants used that correspond to the services rendered unless otherwise agreed upon.
- These units must be clearly indicated on the vendor invoices submitted with the claim. If the units do not match or are not noted, the revenue code 278 will be denied unless otherwise agreed upon.
- If implants are purchased by the provider in bulk, the units that apply to the claim billed must be noted on the invoice or the revenue code 278 will be denied unless otherwise agreed upon.

Facilities will not be reimbursed for implants and supplies that are presumed contaminated, considered a waste and were not implanted in the patient. Some examples are:

- Any items that were prepared or opened during a case but **not** used or implanted into the patient;
- Items opened by mistake;
- Change of mind by the surgeon to use an item for the patient;
- Equipment failure/technical difficulties; and
- Surgery case cancellation.
- Large packages of supplies or implants when more appropriate packaging can be purchased

References:

https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/ImplantsandProsthetics/

Policy Update History:

Approval Date	Description
07/25/2017	New policy
06/11/2018	Annual Review
11/07/2018	Verbiage updates